You have contacted this facility and indicated a desire to be considered for admission. Your name will be placed on our waiting list after you substantially complete and return this application.

Please check off all the communities in which you are interested:

Skilled Nursing Communities
- Jerome Home
- Jefferson House
- Southington Care Center

Assisted Living Communities
- Arbor Rose
- Cedar Mountain Commons
- Mulberry Gardens of Southington
- The Orchards at Southington

SMOKE FREE ENVIRONMENT

Jerome Home: 975 Corbin Avenue • New Britain, CT 06052 • 860.229.3707
Jefferson House: 1 John H. Stewart Drive • Newington, CT 06111 • 860.667.4453
Southington Care Center: 45 Meriden Avenue • Southington, CT 06489 • 860.621.9559
Arbor Rose: 975 Corbin Avenue • New Britain, CT 06052 • 860.229.3707
Cedar Mountain Commons: 3 John H. Stewart Drive • Newington, CT 06111 • 860.665.7901
Mulberry Gardens of Southington: 58 Mulberry Street • Plantsville, CT 06479 • 860.276.1020
The Orchards at Southington: 34 Hobart Street • Southington, CT 06489 • 860.628.5656
Hartford HealthCare Senior Services
Application for Admission

**Vital Statistics**

Name________________________________________ Telephone________________________
Address____________________________________ City_________________ State_______ Zip Code_____________
Sex □ M □ F Date of Birth______________________ Place of Birth_____________________
Marital Status____________________ Religion______________ Place of Worship_____________________
Occupation (Current or Former) ____________________________

Type of Placement Being Sought (Please Check):
□ Short Term Rehab □ Hospice Care □ Long Term Care □ Assisted Living

**Medical Information**

Present Location_____________________________________________________________________________________

If Hospital/Health Facility, Date of Admission_____________________________________________________________

Admitting Diagnosis___________________________________________________________________________________

Surgery (include dates) ________________________________________________________________________________

Past Medical History___________________________________________________________________________________

Allergies________________________________________________________________________________________________

Current Medications_____________________________________________________________________________________ 

Skin Condition:
Surgical Site________________________________________ Reddened Areas___________________________
Decubitus________________________________________ Treatment___________________________
Diet________________________________________ HT_____________WT_________________

Mental Status:
□ Alert □ Oriented □ Confused □ Disoriented □ Forgetful
□ Vague □ Non-responsive □ Depressed

Behavior Patterns:
□ Cooperative □ Wanders □ Paces □ Combative □ Verbally Abusive
□ Resistive to Care □ Easily Agitated □ Other __________________________
Restraints □ Waist □ Vest
Restraints □ Always □ Daytime □ Nighttime □ As Needed □ None
Current Therapies
- PT
- OT
- Speech
- Other

**Functional Data Summary**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
<th>Minimal Assist (Supervise)</th>
<th>Maximum Assist (1-2 Person)</th>
<th>Unable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td>G Tube</td>
<td></td>
</tr>
<tr>
<td>Transferring</td>
<td></td>
<td></td>
<td>NG Tube</td>
<td></td>
</tr>
<tr>
<td>Ambulating</td>
<td></td>
<td></td>
<td>Hoyer Lift</td>
<td></td>
</tr>
</tbody>
</table>

**Continence**
- Continent
- Incontinent
  - If Incontinent:
    - Urine
    - Stool
- Foley Catheter
- Suprapubic Catheter
- Texas Catheter (External Device)
- St. Catheter
- Colostomy
- Ileal Conduit

**Mechanical Aids**
- Oxygen/Liters

**Pace Maker**
- Yes
- No
- Date Inserted

**Prosthesis (Type):**

**History of Psychiatric Problems or Disorders (Include Details and Dates of Hospitalization):**

**History of Alcohol or Substance Use? If Yes, Describe:**

**Smoker**
- Yes
- No

**Miscellaneous Information**

<table>
<thead>
<tr>
<th>Information</th>
<th>Address &amp; Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician</td>
<td>Address &amp; Phone</td>
</tr>
<tr>
<td>Other Physician(s)</td>
<td>Address &amp; Phone</td>
</tr>
<tr>
<td>Attorney</td>
<td>Address &amp; Phone</td>
</tr>
<tr>
<td>Advance Directives</td>
<td>Address &amp; Phone</td>
</tr>
<tr>
<td>If Yes, please indicate:</td>
<td>Address &amp; Phone</td>
</tr>
<tr>
<td>- POA</td>
<td></td>
</tr>
<tr>
<td>- DPOA</td>
<td></td>
</tr>
<tr>
<td>- HCA</td>
<td></td>
</tr>
<tr>
<td>- Living Will</td>
<td></td>
</tr>
<tr>
<td>- Organ Donor</td>
<td></td>
</tr>
<tr>
<td>- Conservator</td>
<td></td>
</tr>
<tr>
<td>During the last 60 days, has there been a stay in a hospital or nursing facility? Yes</td>
<td>If so, please indicate where and when stay took place.</td>
</tr>
<tr>
<td>Have Home Care Services been used in the past?</td>
<td></td>
</tr>
<tr>
<td>If so, please indicate which agency.</td>
<td></td>
</tr>
<tr>
<td>Funeral Home Preference:</td>
<td>Address:</td>
</tr>
<tr>
<td>Have arrangements been made?</td>
<td>Prepaid?</td>
</tr>
</tbody>
</table>
Emergency Contact:

Primary Contact
Name ___________________________________________ Relationship ________________________________
Address ___________________________________________ Home Phone ________________________________
City ___________________________ State _______ Zip Code ____________
Work Phone ___________________________ Cell Phone ___________________________ E-mail ___________________________

Secondary Contact
Name ___________________________________________ Relationship ________________________________
Address ___________________________________________ Home Phone ________________________________
City ___________________________ State _______ Zip Code ____________
Work Phone ___________________________ Cell Phone ___________________________ E-mail ___________________________

Send update letters to ____________________________________________________________
Power of Attorney (POA) __________________________________________________________

ATTACHED FINANCIAL DISCLOSURE FORM MUST ALSO BE COMPLETED.
(All information supplied will remain confidential. Application cannot be processed without this information.)
Social Security Number ___________________________ Medicare Number ___________________________
Medicaid Number (Title 19) _____________________ Pending? □ Yes □ No
Medicaid Caseworker’s name _____________________ Phone ________________________________
Managed Medicare, Commercial, Medicare Supplement ______________ Policy No. ____________________
Does Applicant Own a Long Term Care Insurance Policy? ________________________________
Name of Company __________________________________ Is this a Partnership Approved Policy? __________

Veteran (or spouse of a veteran) □ Yes □ No U.S. Citizen □ Yes □ No

Signature of person completing application _____________________________________________
Date of Completion ________________________________________________________________
Applicant’s Name: ___________________________ Date: __________

The applicant and/or responsible party may be required to submit copies of all current accounts (checking, savings, money market, mortgage, etc.) upon completion of this form and at the time of admission.

<table>
<thead>
<tr>
<th>Applicant’s Own income-list GROSS amount</th>
<th>Spouse’s income-list GROSS amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security</td>
<td>Social Security</td>
</tr>
<tr>
<td>$ ___________ /Mo</td>
<td>_________ /Mo</td>
</tr>
<tr>
<td>Pension</td>
<td>Pension</td>
</tr>
<tr>
<td>$ ___________ /Mo</td>
<td>_________ /Mo</td>
</tr>
<tr>
<td>Annuity</td>
<td>Annuity</td>
</tr>
<tr>
<td>$ ___________ /Mo</td>
<td>_________ /Mo</td>
</tr>
<tr>
<td>Interest</td>
<td>Interest</td>
</tr>
<tr>
<td>$ ___________ /Mo</td>
<td>_________ /Mo</td>
</tr>
<tr>
<td>Dividends</td>
<td>Dividends</td>
</tr>
<tr>
<td>$ ___________ /Mo</td>
<td>_________ /Mo</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
</tr>
<tr>
<td>$ ___________ /Mo</td>
<td>_________ /Mo</td>
</tr>
</tbody>
</table>

Not applicable ____

Social Security $ ___________ /Mo
Pension $ ___________ /Mo
Annuity $ ___________ /Mo
Interest $ ___________ /Mo
Dividends $ ___________ /Mo
Other $ ___________ /Mo

Does the applicant receive income from or have any interest in a trust? Yes____No____

Does the applicant’s spouse receive income from or have any interest in a trust? Yes____No____

Will the money in this trust be available for the applicant’s care? Yes____No____

Does the applicant have a Long Term Care Insurance policy? Yes____No____

Has the applicant ever applied for any other benefits (VA benefits, Pilot Program) that will potentially give additional income? Yes____No____

If yes, please describe what benefits have been applied for and the date of application.
____________________________________________________________________________
____________________________________________________________________________

Applicant’s Assets

(Note: If any asset is jointly held, please give name of joint owner. If married, list all assets owned by the applicant and his/her spouse, regardless of whether the assets are owned individually or jointly).

Properties

Address and approximate value: ________________________________

Names on Deed: ___________________________________________________________________

Does the spouse live in the home? Yes____ No____

What is the amount of equity in the home: $ __________________________

Mortgage notes held on the property: ________________________________
Stocks and Bonds - Please describe and give approximate value

Bank Accounts
Bank: ___________________________ Type of account: ___________________________ Single/joint with whom: ___________________________ Balance: ___________________________

Life Insurance - List only those policies having a cash surrender value and give approximate surrender value.

Annuities - Has the applicant purchased or does the applicant receive income from any annuity? If yes, please describe. Please list specifics with each annuity (monthly payments and/or yearly payment).

Transfer of Assets within 60 months (5 years)
Within 60 months (5 years) prior to the date of this application, has the applicant or spouse given away assets of any kind (cash, securities, real estate, etc.) or transferred assets of any kind?
Yes____ No____
If so, please describe fully all such gifts or transfers of $500 or more, including the asset transferred, date of transfer, names, addresses and relationship of the person to whom the gift was made and the value of the gift or transfer.

Within 60 months prior to the date of this application, has the applicant or spouse created a trust or placed funds or any other assets in a trust that already exists? Yes____ No____
If so, please describe fully all existing or newly created trusts.
If signed by the Applicant:
I hereby certify that this is a true and complete statement of my (and if applicable, my spouse’s) income and assets and any gifts or transfers in excess of $500 and any trusts created or transfers of any assets to any trust that I or my spouse have made.

__________________________
Applicant Signature

__________________________
Date

If signed by the Responsible Party:
I certify that I have investigated the applicant’s financial records and that this is a true and complete statement of the applicant’s income and assets and any gifts or transfers in excess of $500 and any trusts created or transfers of any assets to any trust that the applicant or his or her spouse has made.

__________________________
Person Acting for Applicant

__________________________
Print Name

__________________________
Title

__________________________
Date